Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karl Armstrong, a prisoner at Merseybank Approved Premises, on 23 May 2022

A report by the Prisons and Probation Ombudsman

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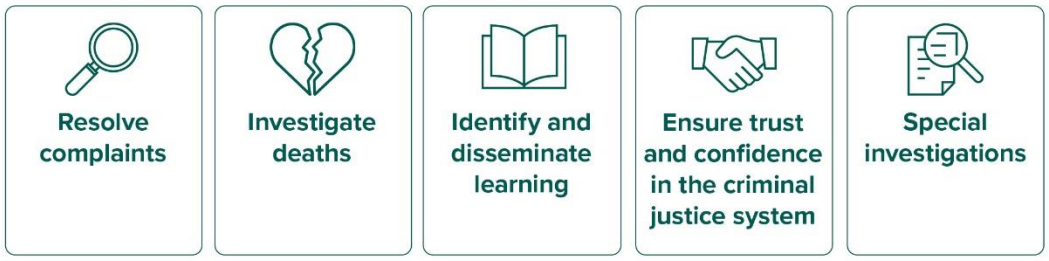
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Armstrong was found unresponsive in his room at Merseybank Approved Premises on 23 May 2022. He was 52 years old. I offer my condolences to Mr Armstrong's family and friends.

The post-mortem examination concluded that Mr Armstrong died as a result of the combined effects of cocaine and opiates. Mr Armstrong had been released from prison six days before he died. He had a history of substance misuse and mental health issues and in the days before his death, he displayed signs of paranoia. However, staff recorded no concerns about his substance use.

Our investigation found that the night security worker at Merseybank AP did not fulfil his responsibilities to the expected standard. He had already been suspended by the AP manager and subsequently resigned from his position.

When staff became concerned about Mr Armstrong's mental health, they began the process to recall him to prison. Prisons are not places of safety and staff need to know the right channels for escalating concerns about a resident's mental health.

This version of my report, published on my website, has been amended to remove the names of staff and residents involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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Summary

Events

1. On 17 May 2022, Mr Karl Armstrong was released on licence from HMP Buckley Hall to live at Bunbury House Approved Premises (AP). He had a history of substance misuse and mental health problems, including episodes of paranoia. He was not given a naloxone kit (which can reverse the effects of an opioid overdose).

2. On 19 May, Mr Armstrong reported that he was under threat from unidentified sources at Bunbury House and staff moved him to Merseybank AP. The police concluded that there was no evidence that he was under threat.

3. On 21 May, Mr Armstrong told AP staff that he was still under threat. At 11.00pm that evening, when staff tried to do a welfare check, Mr Armstrong had barricaded his door with furniture. Mr Armstrong eventually let staff in and told them that he was feeling paranoid. Staff informed the AP manager of the situation. The police confirmed that Mr Armstrong had not reported anything to them and there was no intelligence to suggest he was under threat.

4. The next morning, staff spoke to Mr Armstrong about the previous evening and tried to get more information about his fears. Mr Armstrong told them that he could hear people talking on his phone and that it had been hacked. Based on his presentation, staff considered that Mr Armstrong might be suffering with his mental health rather than under genuine threat. Mr Armstrong's community offender manager was not informed so he was not referred to community mental health services.

5. At 7.00pm, police arrived at the AP after Mr Armstrong reported a firebomb exploding outside his window. The police offered to take Mr Armstrong to a crisis unit, but he declined. The manager decided to start an emergency recall to prison to keep Mr Armstrong safe.

6. The manager, staff and Mr Armstrong agreed to increased welfare checks overnight. A night security worker refused to participate in any additional welfare checks on Mr Armstrong because he said that Mr Armstrong had mental health issues. He also failed to follow instruction and check with the police that Mr Armstrong's recall to prison was being actioned.

7. At approximately 11.00pm, the night security worker conducted a routine check on Mr Armstrong and saw he was lying on the floor, snoring loudly.

8. On 23 May at 6.00am, the night security worker conducted welfare checks on residents. Mr Armstrong did not respond when he knocked on his door, so he entered his room. He said that there were clear signs that Mr Armstrong had died, and he also saw drug paraphernalia in the room.

9. The night security worker finished checking the other residents before alerting the other member of staff on duty that there was a medical emergency. AP staff called an emergency ambulance and carried out cardiopulmonary resuscitation (CPR) until paramedics arrived. Mr Armstrong was pronounced dead at approximately 6.14am.

10. Mr Armstrong's next of kin phoned the AP later that day and asked whether Mr Armstrong had been moved. The member of staff who answered the phone thought the police had already broken the news of Mr Armstrong's death, when they had not yet done so, and so the family learnt of his death by chance.

Findings

11. The AP night security worker refused to conduct regular welfare checks on Mr Armstrong as he should have done. When he found Mr Armstrong unresponsive the following morning, he did not promptly raise the alarm. Staff tried to resuscitate Mr Armstrong despite clear signs he had been dead for some time.

12. Probation staff decided to initiate a recall to prison due to Mr Armstrong's deteriorating mental health which was neither the usual process, nor the best option, for protecting someone experiencing a mental health crisis.

Recommendations

- The National Approved Premises Team should ensure that all staff are given clear guidance about and understand the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council guidelines.

- The Bunbury House AP Manager should ensure that naloxone is offered to residents known to have substance misuse issues during the induction process.

- The AP Manager should ensure that staff understand how to escalate concerns about a resident's mental health.

The Investigation Process

13. The investigator issued notices to staff and residents at Merseybank Approved Premises informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator requested information from Merseybank AP on 25 May 2022. He obtained copies of relevant extracts from Mr Armstrong's probation and medical records.

15. The investigator interviewed four members of staff remotely between 14 and 25 July.

16. We informed HM Coroner for Liverpool and the Wirral area of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Armstrong's next of kin, his mother and his wife, to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Armstrong's next of kin asked the following questions:

    - why was Mr Armstrong not checked more frequently?
    - could anything more have been done to help Mr Armstrong?

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified some minor factual inaccuracies, which we have amended in this report.

16. We sent a copy of our initial report to Mr Armstrong's family. They did not notify us of any factual inaccuracies.

Background Information

Merseybank Approved Premises

19. Approved Premises (APs) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

20. Merseybank Approved Premises in Liverpool is managed by HM Prison and Probation Service (HMPPS). It has capacity for 24 residents (although this had been reduced to 22 residents during the COVID-19 pandemic). Residents are expected to attend daily residents' meetings and there is a curfew between 11.00pm and 6.00am. Each resident is allocated a keyworker to oversee their progress and well-being, and to ensure that they adhere to licence conditions and the AP's rules. Probation Service employees are on duty at Merseybank 24 hours a day with support from Sodexo security contractors at night.

Previous deaths at Merseybank

21. In the two years before Mr Armstrong's death there was one other death at Merseybank AP. The other death was also drug related, and a recommendation was made to the AP manager to ensure staff completed welfare checks according to requirements, including getting a response from residents. The AP accepted the recommendation and discussed it in the team meeting as well as recirculating the Safe Working Practices document.

Key Events

22. Mr Armstrong was sentenced to 12 years in prison in 2014 for various offences. After his release, he would remain on licence until 2026.

23. On 17 May 2022, Mr Armstrong was released from HMP Buckley Hall and went to live at Bunbury House AP.

Bunbury House AP

24. Mr Armstrong had a history of substance misuse which was linked to his offending and was highlighted in the documents Buckley Hall had sent to the AP. Mr Armstrong received an induction on arrival at Bunbury House, where the dangers of reduced drug tolerance and therefore the risk of accidental overdose were explained to him. Mr Armstrong was required to take drug tests as required by AP staff as part of his licence conditions, as well as keeping to a curfew of 11.00pm – 6.00am. He was referred to the local drug and alcohol service, but did not attend any appointments. There is no record that Mr Armstrong was offered naloxone, a preventative medication for opiate overdose, despite knowledge that he was a drug user.

25. Mr Armstrong's records indicate that he was diagnosed with post-traumatic stress disorder (PTSD) and suffered from night terrors. Mr Armstrong had historic episodes of paranoia but was not prescribed any medication for it. AP staff were not aware of his historic mental health issues, so he was not referred to community services. There is no evidence that he was referred to community mental health services before his release.

26. On 19 May, Mr Armstrong rang his wife and said he was under threat; she in turn rang the AP. AP staff spoke to Mr Armstrong who alleged an unnamed resident at the AP had told him there was a hit out on him, but he could not or would not say who and why. Probation staff and police officers met with him and it was decided he would be transferred to Merseybank AP where he said that he would feel safer. That day, Mr Armstrong attended a drug treatment appointment, no issues were recorded. Mr Armstrong moved to Merseybank AP.

Merseybank AP

27. From 19 to 21 May, curfew check records show that staff routinely checked on Mr Armstrong twice a day, once in the morning and once in the evening.

28. On 19 May, Mr Armstrong attended a drug treatment appointment.

29. At around 10.00pm on 21 May, Mr Armstrong told staff that the person he was under threat from someone who knew he had moved to Merseybank. Staff asked for the name of the person, but Mr Armstrong refused to disclose it.

30. At around 11.00pm, staff went to Mr Armstrong's room for a curfew check and noticed that he had barricaded the door. The AP staff repeatedly asked him to open the door and he eventually did. He said that he was fine but was feeling paranoid. Staff called Merseyside Police and asked whether they had any further information

about the alleged threats. The police had no record of any threats reported by Mr Armstrong or any other relevant information.

31. The duty manager of the AP recorded that she had instructed staff to monitor Mr Armstrong overnight, and that they would need to review the situation the following day.

32. On 22 May at around 1.00am, police officers attended Merseybank to check on Mr Armstrong. AP staff told them that Mr Armstrong had settled and there were no particular concerns at that time.

33. At about 10.00am on 22 May, a probation officer spoke with Mr Armstrong to assess his risk of harm. She recorded that he was on his way out of the AP, but she and another probation officer convinced him to speak to them. Mr Armstrong told them that he was being threatened but he did not know who by. He said he had heard the threats through walls and from his phone. He said that those threatening him had gained access to his phone. One of the probation officers asked Mr Armstrong whether he had any thoughts of harming himself and he said he did not. Mr Armstrong left the AP after the conversation.

34. Around midday, Mr Armstrong returned to the AP. Staff spoke to him as he was signing in, and he said that he did not feel safe in the AP, but he needed sleep. Staff reminded him that he could speak to them and tried to reassure him that he was safe.

35. At 6.50pm, two police officers arrived at Merseybank. They said that Mr Armstrong had called the emergency services and said that a petrol bomb was going off outside his window, and also that there were people outside who wanted to kill him. Police officers went to speak with Mr Armstrong who apologised and said he didn't know what had happened. One of the probation officers said that he had moved the furniture in his room against the window.

36. One of the police officers asked to speak with Mr Armstrong alone in the medication room. The probation officers discussed the possibility of the police taking Mr Armstrong to a place of safety under the Mental Health Act. It appears that AP staff did not directly ask the police to do this, but waited to see what the police officer's assessment was. Shortly after, the police officers concluded that they did not need to take Mr Armstrong to a place of safety. They told Mr Armstrong they could take him to a community mental health crisis team if he wanted. He declined.

37. The duty manager said that she discussed with her manager recalling Mr Armstrong to prison to make sure he was kept safe. She decided that a recall was appropriate as she felt the AP could not manage Mr Armstrong's needs and she could not think of any other options that would reduce the risk quickly. The duty manager sent the recall paperwork to the Public Protection Unit. She did not provide a clear reason for the recall and cited Mr Armstrong's poor behaviour as the reason.

38. During interview, the duty manager said that she knew an emergency recall was not appropriate for someone suffering from a mental health crisis, but she did not think any other option would keep Mr Armstrong safe as quickly. She added that once emergency services had decided not to detain someone under the Mental Health

Act, approved premises staff were left to deal with a situation for which they were not sufficiently trained.

39. At around 8.00pm, the Public Protection Team revoked Mr Armstrong's licence, meaning that he was going to be recalled to prison. The local police point of contact was informed to action the arrest.

40. The duty manager said she and the two probation officers agreed that staff should check Mr Armstrong every 45 minutes through the night.

41. One of the probation officers said that the night shift staff, a night security worker employed by Sodexo and a worker employed by the Probation Service, had arrived. She told them what had happened and the Sodexo staff member said he would not check on Mr Armstrong because he was "fucking mental". In interview, he denied saying this. The probation officer said she then addressed the handover to the probation staff member and discussed the details of Mr Armstrong as well as other residents.

42. At 8.25pm, the duty manager phoned the Sodexo staff member and told him to contact the police to ensure Mr Armstrong was arrested.

43. The Sodexo staff member said he was not told that he had to conduct any extra welfare checks, and that he only checked on Mr Armstrong at the scheduled time of 11.00pm. The probation staff member said staff did not tell her that extra checks on Mr Armstrong were needed. Three members of staff said the Sodexo staff member was aware extra checks had been agreed, although this was not formally recorded. The probation staff member did not participate in the welfare checks although she did carry out her required landing checks throughout the night.

44. At 11.00pm, the Sodexo staff member said that he checked on Mr Armstrong. He reported that Mr Armstrong was lying on the floor in his room snoring loudly. He said that this did not stand out to him as an issue or concern. He did not notice any drug related items at this time. He added that the previous evening, the AP manager had told him that if Mr Armstrong was settled he should be left alone. The Sodexo staff member said he did not wake Mr Armstrong because of his PTSD diagnosis and knowledge that he suffered from night terrors. He did not contact the police as instructed by the AP manager.

Events of 23 May

45. At 6.00am on 23 May, the Sodexo staff member conducted the morning welfare checks. He did not have a radio with him. He said that when he went into Mr Armstrong's room, he saw him lying at the end of his bed on his side. He said Mr Armstrong had foam coming out of his mouth and he was grey in colour. He thought Mr Armstrong was dead and that rigor mortis had set in. He touched Mr Armstrong and said he was cold and his skin was waxy. He said that there was a lot of drug paraphernalia in the room.

46. He left the room then continued with his checks on other residents. He said that he believed this was the process staff had been instructed to follow in this circumstance and said this came from emails which he had been sent. He said he washed his hands because he had touched a dead body and then told the

probation service staff member, who called the emergency services. They both then went to Mr Armstrong's room with a defibrillator.

47. The Sodexo staff member said he did chest compressions for around eight to ten minutes. The probation staff member said the Sodexo staff member did not do chest compressions while she was in the room. She said they attached the defibrillator, and it advised CPR so she began chest compressions.

48. At approximately 6.13am, paramedics arrived at Mr Armstrong's room and confirmed that Mr Armstrong had died.

49. At 6.15am, the probation staff member called the duty manager to tell her. The duty manager said she asked if Mr Armstrong had been checked regularly, and the staff member told her that he had not been regularly checked.

50. At 7.15am, the duty manager arrived at the AP and spoke with the two night staff. She told us that the Sodexo staff member said that when he found Mr Armstrong, he formed the view that he was dead, and as a result carried on the rest of the checks on other residents. The duty manager informed the AP manager that she had concerns about the Sodexo staff member's conduct.

Contact with Mr Armstrong's family

51. On 23 May at 4.00pm, a residential support worker answered a call from Mr Armstrong's wife. Mr Armstrong's wife asked where he had been moved to, and the support worker believed she was talking about his body. At that time, however, Mr Armstrong's wife was not aware of his death and learned about it via the call. The support worker was under the impression that Mr Armstrong's next of kin had been informed that morning by the police.

52. The support worker apologised for the genuine misunderstanding.

Support for prisoners and staff

53. After Mr Armstrong's death, the AP manager debriefed the staff and residents to ensure they had the opportunity to discuss any issues, and to offer support.

Post-mortem report

54. The post-mortem report found the primary cause of Mr Armstrong's death was cocaine and opiate toxicity. The report identified that the combination of cocaine and heroin was likely to have placed an increased strain on his cardiorespiratory system.

55. The inquest, held on 28 September 2022, concluded that Mr Armstrong's death was drug related.

Findings

Welfare checks

56. Mr Armstrong had only been released from prison six days before he died, and during that time, he displayed clear signs of paranoia and his behaviour was of such concern to AP staff that they had begun the process to recall him to prison. He had a known history of mental health problems and substance misuse although staff recorded no concerns about substance misuse while he was at Merseybank AP.

57. The AP Safe Working Practices (SWP) published in January 2022, says that checks are aimed at ensuring the welfare of residents, and can be set as high as five per hour if there is any risk of drug misuse, overdose and suicide and self-harm. The frequency should reflect the risk and they should occur at irregular intervals.

58. On 22 May, after Mr Armstrong had displayed further paranoid behaviour, the AP manager and colleagues decided staff should check Mr Armstrong every 45 minutes through the night. This was an appropriate decision given Mr Armstrong's presentation. They did not record the frequency of checks required in any of the AP paperwork, but the staff told us that they had instructed the Sodexo staff member to carry out the checks and he had responded that he would not because of Mr Armstrong's mental health issues. He denied having said that, but in any case, he did not check Mr Armstrong every 45 minutes but only checked him at 11.00pm that night.

59. The other night worker said that she was not aware that Mr Armstrong should be checked every 45 minutes (and these checks were the Sodexo staff member's responsibility to conduct).

The actions of the Sodexo staff member

60. The Sodexo staff member's actions fell short of acceptable on the night of 22/morning of 23 May. He clearly failed in his duty of care to Mr Armstrong and in his professional responsibilities when he:

- failed to conduct the required welfare checks on Mr Armstrong;
- used offensive terminology to describe Mr Armstrong's mental health;
- failed to follow up Mr Armstrong's emergency recall to prison as instructed; and
- failed to promptly summon emergency help for Mr Armstrong when he found him unresponsive.

61. After Mr Armstrong died, the AP manager suspended the Sodexo staff member from duty pending an internal investigation into his actions. We consider that this was appropriate. The Sodexo staff member resigned before the outcome of the investigation. We therefore make no recommendation.

Resuscitation

62. European Resuscitation Council Guidelines state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile.” The guidelines give examples of futility as including the presence of rigor mortis. Mr Armstrong’s limbs were completely stiff, which indicated that rigor mortis was present. Rigor mortis normally sets in between two and six hours after death, indicating that Mr Armstrong had been dead for some time when he was found. Despite this, AP staff began CPR while waiting for the paramedics to arrive. We understand the wish to continue resuscitation until death has been formally recognised, but trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

    The National Approved Premises Team should ensure that all staff are given clear guidance about and understand the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council guidelines.

Provision of naloxone

63. There is no record of Mr Armstrong being offered naloxone during his induction at Bunbury House AP. However, naloxone was available for staff to use at Merseybank.

64. The provision of naloxone to Mr Armstrong could have potentially altered the outcome of events. As such, we make the following recommendation:

    The Bunbury House AP Manager should ensure that naloxone is offered to residents known to have substance misuse issues during the induction process.

Decision to recall

65. The duty manager’s decision to initiate a recall due to Mr Armstrong’s paranoid behaviour was not the usual process for protecting someone experiencing a mental health crisis. She explained in interview that she was aware Mr Armstrong had not done anything wrong, and she was hoping that the police would detain him under the Mental Health Act.

66. She explained that once emergency services have decided not to detain someone under the Mental Health Act, AP staff are left with few options and are not sufficiently trained to deal with the situation.

67. She noted on the recall paperwork that Mr Armstrong was being recalled for negative behaviour, which did not accurately reflect the situation. While it was an unusual set of circumstances, and we understand that AP staff were concerned for Mr Armstrong’s safety and did not know how else to support him, the decision to recall was not appropriate. Prisons are not places of safety and we consider that the AP staff should have explored other options. For example, had Mr Armstrong’s community offender manager been promptly informed of Mr Armstrong’s deteriorating mental health, they could have pursued a referral to the community

mental health services. When staff became particularly concerned for his safety, they could have called for an ambulance so that paramedics could consider whether he needed to be hospitalised or detained under the Mental Health Act. We make the following recommendation:

The AP Manager should ensure that staff understand how to escalate concerns about a resident's mental health.

AP Manager to note

68. None of the staff involved in the decision to increase the frequency of welfare checks on Mr Armstrong recorded the decision in writing on any of the AP paperwork. The AP manager should remind staff of the importance of making a written record of such decisions.

69. When an AP resident dies, the police are normally asked to break the news to the next of kin. The APM does not, therefore, include any formal process for AP staff to inform the next of kin. However, the APM Annex D, which was in force at the time Mr Armstrong died, required APs to appoint a responsible member of staff to act as family liaison officer. It is not clear that Merseybank had appointed a family liaison officer by the time Mr Armstrong's wife called. While this was clearly a genuine mistake on the part of the staff member who answered the telephone, it must have been incredibly distressing for Mr Armstrong's family.

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